

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins Dallas, TX 75219	MDR Tracking No.: M4-03-7452-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Highmark Casualty Insurance Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: C135C5864199

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/27/02	08/27/02	90844	\$122.00	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a Position Summary.

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary; however, on the response to the TWCC-60 the carrier representative indicated the adjustor was having the bills "re-priced for payment".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 90844 for date of service 08/27/02. On January 26, 2005 the Requestors representative, Kathy Owens was contacted in regards to the Respondents statement on the TWCC-60. MDR was informed by the Requestors representative that the payment was received and no additional monies were due and that a withdrawal letter would be e-mailed to this MDRO. The e-mail was never received; therefore, per Rule 133.307(m)(1) this case is dismissed with no additional action being taken.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/31/2002	90844	\$122.00	\$122.00				
				Total Left Column:			\$122.00
				Total Amount Due:			\$122.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor has being paid and no further reimbursement is due.

Ordered by:

Marguerite Foster 01-28-05

Authorized Signature	Typed Name	Date of Order
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PARTIAL: YOUR RIGHT TO REQUEST A HEARING

PART VIII: YOUR RIGHT TO REQUEST A HEARING

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Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____